

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

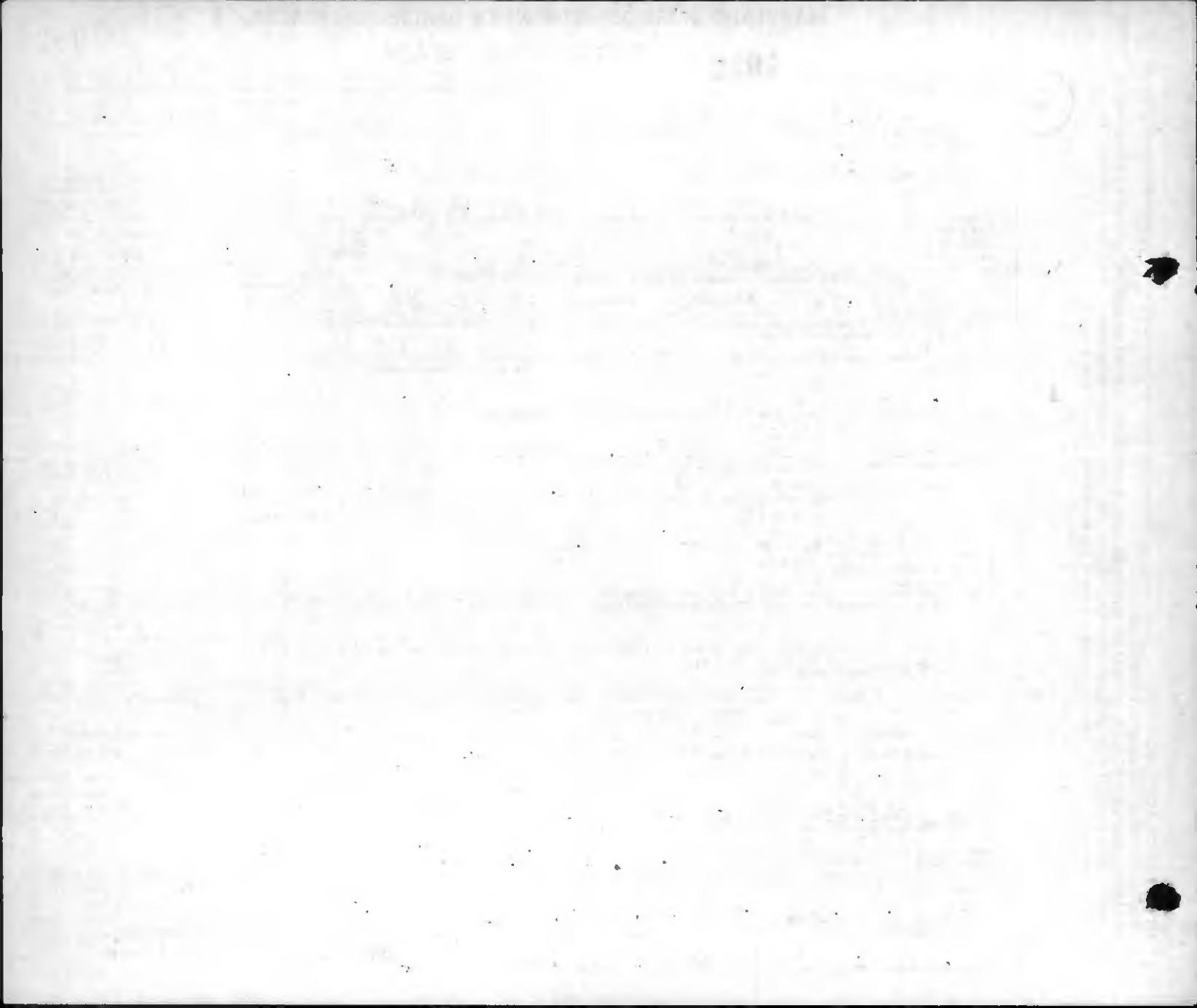
CERTIFICATE OF DEATH

Reg. Dist. No. 03982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b RURAL and give nearest town BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Route # 3	
3. NAME OF DECEASED (Type or print) Clara	First	Middle	Last Beiddell
4. DATE OF DEATH 3 19 1960	Month	Day	Year
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1861
9. AGE (In years last birthday) 98 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Betthards	14. MOTHER'S MAIDEN NAME ESTER Hammond		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NO	INFORMANT JOSEPH C. Beiddell-Rt #3 Berlin, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Senility (c)			
Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH about year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-23 , 19 52 , to 3/12 , 19 60 , that I last saw the deceased alive on 3/12 , 19 60 , and that death occurred at 5P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin, Md			
ACTUAL SIGNATURE Ivory U. Sully, Jr., M.D.		DATE SIGNED 3/24/60	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-26-60	22c. NAME OF CEMETERY OR CREMATORIAL New Bethel Cem	22d. LOCATION (City, town, or county) (State) Berlin, Md
23. FUNERAL DIRECTOR'S SIGNATURE Theron B. Jolley, Salisbury, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE APR 4 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4051

CERTIFICATE OF DEATH

Reg. Dist. No. 03983

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE b. COUNTY Md Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN MD RURAL		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Berlin, Md (RFD#2)	
3. NAME OF DECEASED (Type or print) MABLE		First W.	Middle CATHELL
4. DATE OF DEATH March 16 1960		Month Month	Day Day
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 4/27/08		9. AGE (in years lost birthday) 51 yrs.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edgar Evans	
14. MOTHER'S MAIDEN NAME Mattie Hudson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT HARRY CATHELL Berlin MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-14, 1958, to 3-8, 1960, that I last saw the deceased alive on 3-8, 1960, and that death occurred at 6:00 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory V. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 3/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/60	
22c. NAME OF CEMETERY OR CREMATORIAL St Georges Cem.		22d. LOCATION (City, town, or county) CLARKSVILLE Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Watson & Gray Frankford, Del.		ADDRESS	
24a. REC'D BY REGISTRAR MAR 22 '60		DATE	
24b. REGISTRAR'S SIGNATURE Cuthbert S. Knapp			

CERTIFICATE OF DEETN

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03984

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN lb 66 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN	
3. NAME OF DECEASED (Type or print) VAUGHN EVERETT		First C	Middle ROPER
4. DATE OF DEATH MARCH 5 1960		Last ROPER	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1874
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY OWN STORE	
11. BIRTHPLACE (State or foreign country) BERLIN MD (QFD)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH CROPPER		14. MOTHER'S MAIDEN NAME ELIZABETH TURNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. V. EVERETT CROPPER		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis with 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Acute Pulmonary Edema DUE TO Coronary Artery Disease			
INTERVAL BETWEEN ONSET AND DEATH 10 Min			
Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Herman A. Robbins</i>		DATE SIGNED 3/6/60	
EXAMINER'S NAME (Type) Herman A. Robbins M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/8/60	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BERLIN (State) M.D.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Burbridge Berlin Md</i>		ADDRESS ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 10 '60
		24b. REGISTRAR'S SIGNATURE <i>Collins S. Turner</i>	

EXAMINER'S CERTIFICATE OF OATH

02/22/00

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03985

4048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Mercyter</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN lb <i>3 mo 23 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Snow Hill</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
3. NAME OF DECEASED (Type or print) <i>Decora Mae Jackson</i>		4. DATE OF DEATH <i>March 5 1960</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Poland</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 12 1959</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>Snow Hill, Md</i>	
13. FATHER'S NAME <i>Grace Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Helen Bechler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>70</i>		16. SOCIAL SECURITY NO. <i>None</i> INFORMANT <i>Mr Helen Jackson Snow Hill, Md</i> Address <i>Snow Hill, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHOPNEUMONIA</i> DUE TO <i>491X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Snow Hill</i> (County) <i>Md</i> (State) <i>Md</i>	
21. I certify that I attended the deceased from <i>MARCH 4, 1960</i> to <i>MARCH 5, 1960</i> that I last saw the deceased alive on <i>MARCH 5, 1960</i> , and that death occurred at <i>4 PM</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert C. LaMar</i> ADDRESS <i>104 Bay Street</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M. D.</i> Snow Hill, Maryland			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i> DATE THEREOF <i>March 5, 1960</i>		22b. NAME OF CEMETERY OR CREMATORIAL <i>Baptist Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Snow Hill</i> (State) <i>Md</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. LaMar</i> ADDRESS <i>Snow Hill, Md</i>	
24a. REC'D BY REGISTRAR <i>Mar 8 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carling L. Hause</i>	

NAME OF PUBLISHER

200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03986

Reg. Dist. No.

4046

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
Worcester MARYLAND		Maryland Worcester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb X Pocomoke City					
Pocomoke Home		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS R.F.D.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Mary	Middle Jones				
4. DATE OF DEATH		Month Mar.	Day 5				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years to birthday) 42 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
Female		Negro		June 8, 1917			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Farm Work		Beaufort Co.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
UNKNOWN		Martha JONES					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				Perlie Jones		Pocomoke City, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage (Heart) 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to stab wound DUE TO (c) Homicide							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Working alcohol drink							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Starved by another person following a hearty					
20c. TIME OF INJURY Hours p. m. Mc 14 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, Factory, street, office bldg., etc.) None	20f. (City or town) Pocomoke City, Md	(County) Wicomico Co.	(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE N.E. Sartoris S.M.D.		DATE SIGNED 3/4/60					
EXAMINER'S NAME (Type) N.E. Sartoris M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/60	22c. NAME OF CEMETERY OR CREMATORIAL Beaufort		22d. LOCATION (City, town, or county) Beaufort, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Elgo - Wharton - Newburgh, Ct		ADDRESS		24a. REC'D BY REGISTRAR MAR 18 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

1. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ВІДОМОСТІ ПРО ДІЯЛЬНІСТЬ СІРІЇ МІСІІ
ІНДІЙСЬКИХ АСАСІНІВ

240

McCabe
4044

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03987

1. **NOTIFY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
MARYLAND		b. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
BERLIN		85 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
X 1124 N		1 RF	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
J. A. McCABE		H.	McCABE
4. DATE OF DEATH		Month	Day
March 6		Year	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
M		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 14, 1914
9. AGE (In years less birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours Min.
73 yrs.		Months	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
D		CIVILIAN	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Massachusetts		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOSHUA McCABE		MASSACHUSETTIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
N		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO 1 yr			
DUE TO (c) <u>Coronary Sclerosis</u> 3-4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Herman A. Robbins M.D.		DATE SIGNED 8 Mar 60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL
CREMATION		3/10/60	EVERGREEN
22d. LOCATION (City, town, or county) (State)		BERLIN MD	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE
Burke		Berlin Md	15 '60
24b. REGISTRAR'S SIGNATURE		Arthur E. Hansen	



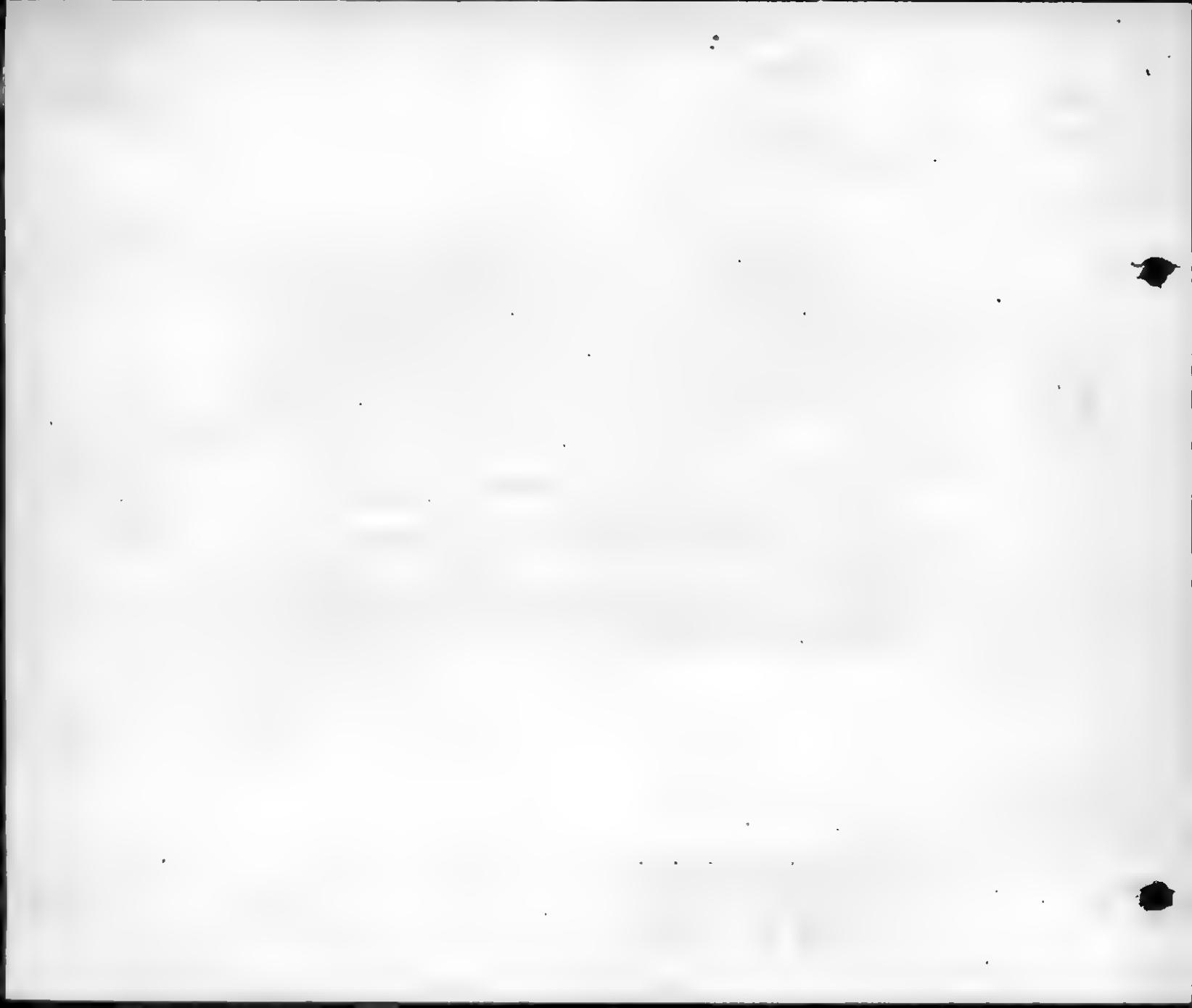
103988

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret H. Melson</i>		First <i>Margaret</i>	Middle <i>H.</i>
4. DATE OF DEATH <i>March 13 1960</i>		Last <i>Melson</i>	Month <i>March</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 10-1869</i>		9. AGE (In years less b. birthday) <i>90/13</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hausfrau</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME <i>Frederick Haubert</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bridgell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Bryon Bell, Snow Hill, Md</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.2</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 mos</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial insufficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lobar pneumonia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1948</i> to <i>3-13-60</i> , that (I) () last saw the deceased alive on <i>3-12-60</i> , and that death occurred at <i>10A</i> M. from the causes and on the date stated above.		22b. DATE SIGNED <i>March 15, 1960</i>	
22c. SIGNATURE <i>Robert C. LaMar</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M. D.</i>		22d. ADDRESS <i>104 Bay Street, Snow Hill, Md</i>	
23a. BURIAL CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>Bethel Methodist</i>	
23c. LOCATION (City, town, or county) <i>Snow Hill</i>		(State) <i></i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>May E. Evans</i>		ADDRESS <i>Snow Hill, Md</i>	25a. REC'D BY REGISTRAR DATE <i>MAR 16 '60</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

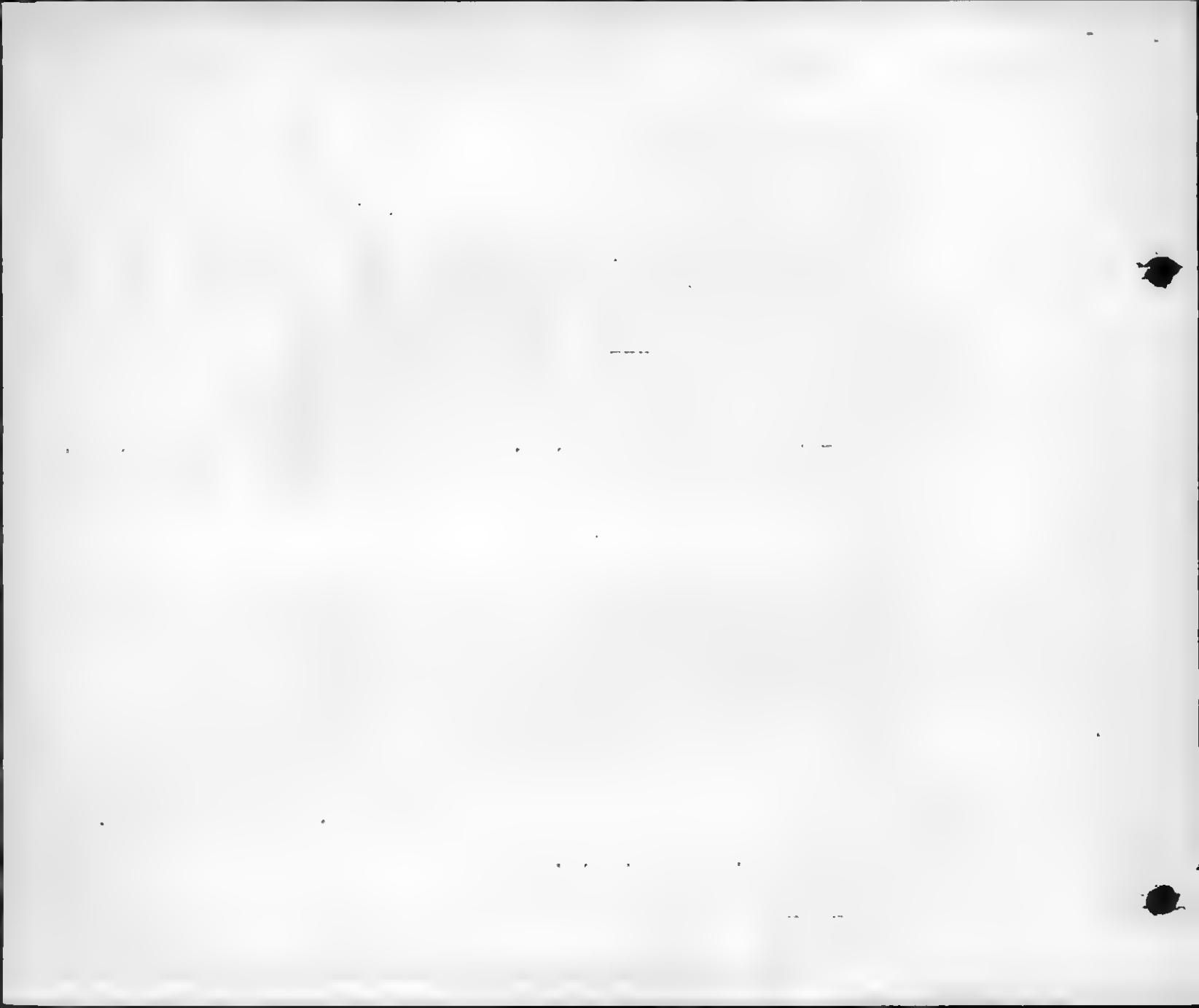
03983

Reg. Dist. No.

4047

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Greenway Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BERTIE	Middle H.	Last MERRILL
4. DATE OF DEATH	Month March	Day 21	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1891
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ...	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Edward Thomas Hope		14. MOTHER'S MAIDEN NAME Sudie B. Bundick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT W. H. Merrill Jr., Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 24 Minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized atherosclerosis		Years Years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthritis, Chronic.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 4, 1959 , to March 24, 1960 , that I last saw the deceased alive on Mar. 21, 1960 , and that death occurred at 302 Market St. Pocomoke City, Md.		ADDRESS (Street, city or town, state) DATE SIGNED 3-22-60	
ACTUAL SIGNATURE Charles W. Trader, M.D.			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-60	
22c. NAME OF CEMETERY Bethany Methodist		22d. LOCATION (City, town, or county) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		24a. REC'D. BY REGISTRAR DATE Mar 28 '60	
ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



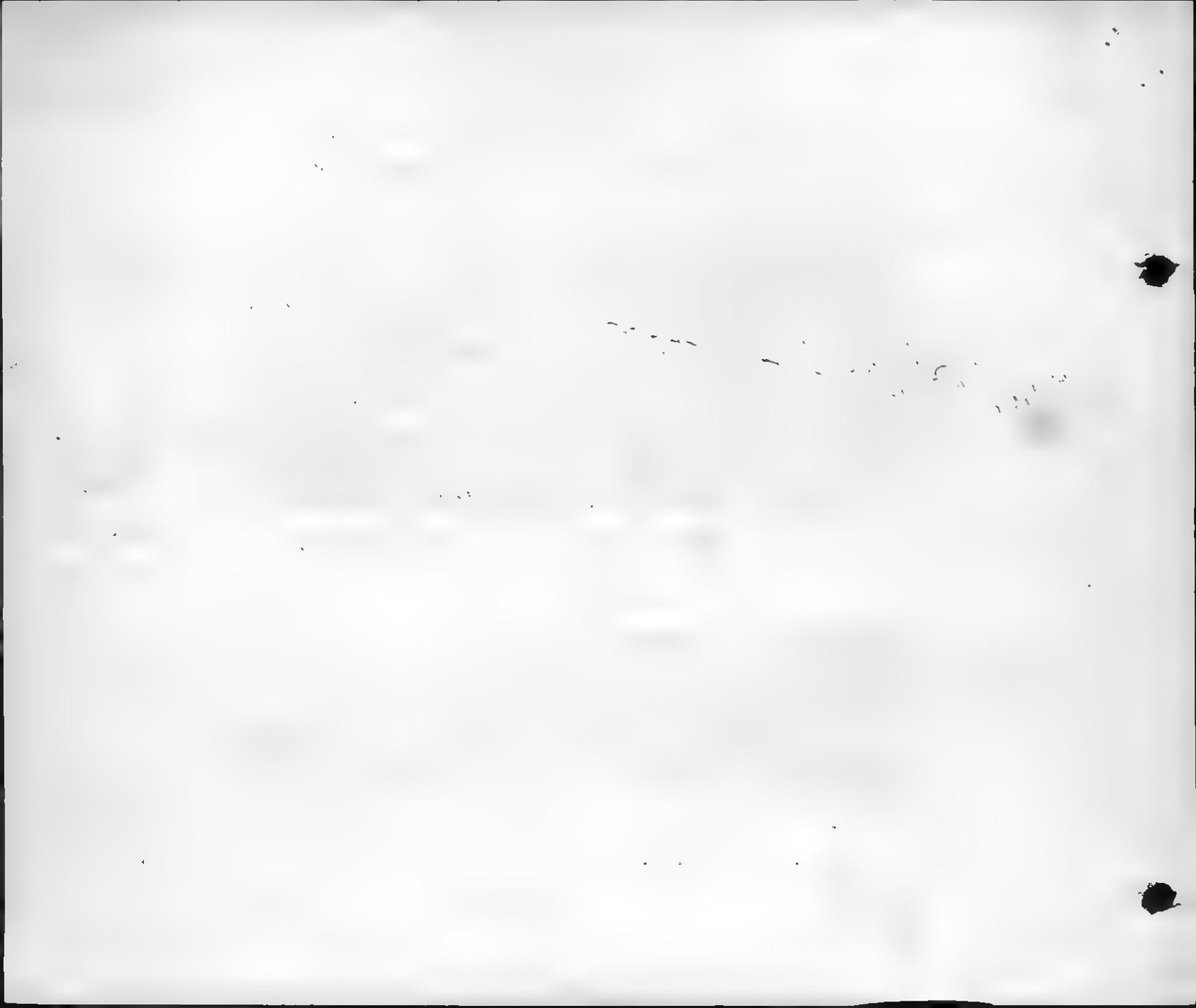
03950

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Worcester</i>	
c. LENGTH OF STAY IN 1b <i>48 hrs</i>		d. STREET ADDRESS <i>Snow Hill</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>204 Bay Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William L. Mills</i>		4. DATE OF DEATH <i>March 14 1960</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>March 21 1911</i>		9. AGE (In years (1st birthday) <i>48 yrs 2 mos</i>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Snow Hill, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Snow Hill, Md</i>		13. FATHER'S NAME <i>Ernest S. Mills</i>	
14. MOTHER'S MAIDEN NAME <i>Annie Lewis</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>11-316-09-437</i>		17. INFORMANT Address <i>Mrs Margaret S. Mills, Snow Hill, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>241X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Myocardial Insufficiency Chronic Bronchitis, asthma <i>6 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchitis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>1956</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>3-12-60</i> and that death occurred at <i>2:00</i> P. M. from the causes and on the date stated above		22b. DATE SIGNED <i>March 15, 1960</i>	
22a. SIGNATURE <i>Robert C. LaMar</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>104 Bay Street, Snow Hill, Md.</i>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial March 17/60</i>		23b. DATE THEREOF <i>March 17/60</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Worcester Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Snow Hill, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton & Sonne</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 16 '60</i>	
ADDRESS <i>Snow Hill, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

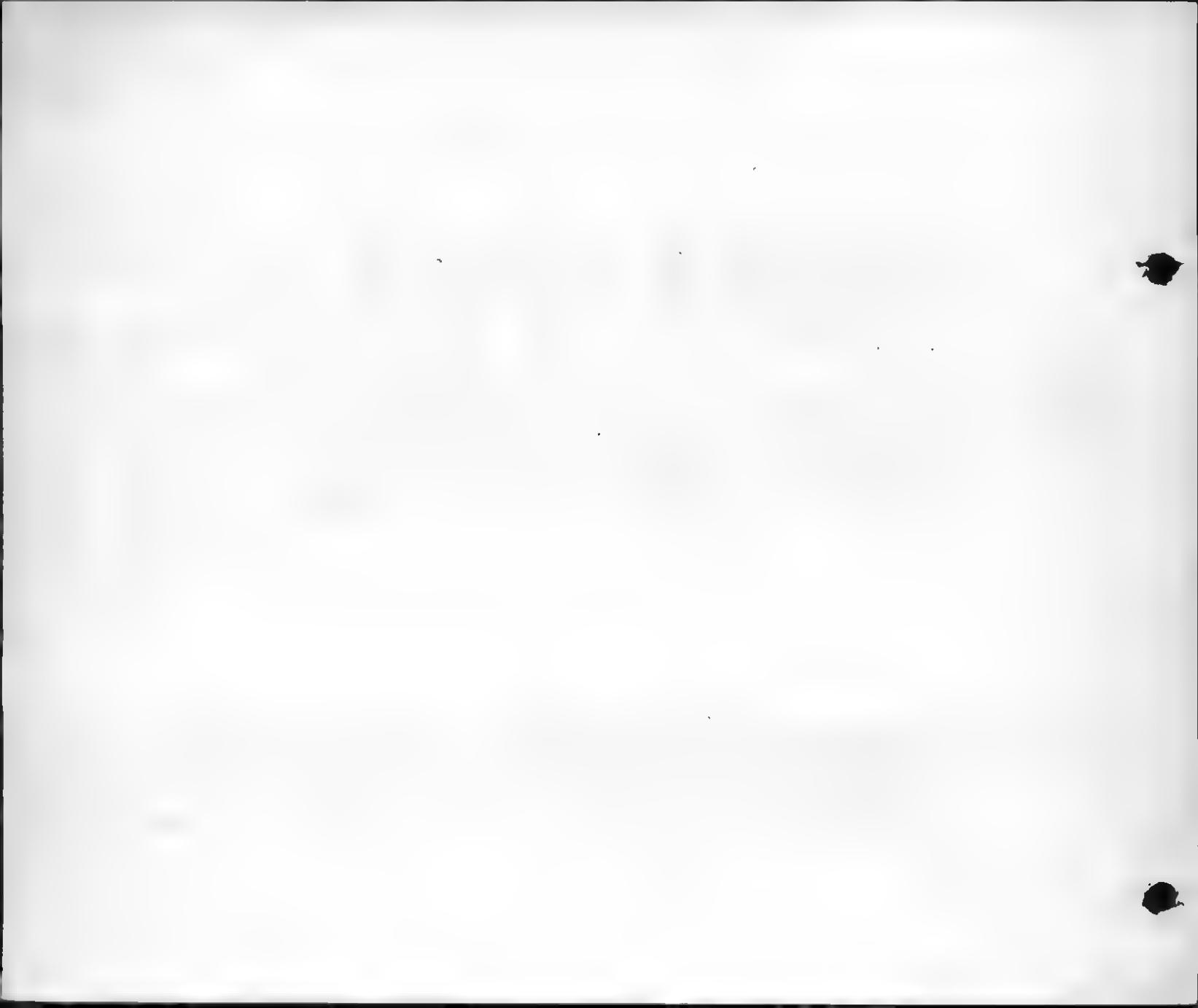
4053

CERTIFICATE OF DEATH

Reg. Dist. No.

03951

1. PLACE OF DEATH a. COUNTY <i>WORCESTER</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>NEWARK</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WORCESTER</i>	
c. LENGTH OF STAY IN lb <i>NEWAIRK</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X NEWARK</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EDWARD FINGER</i>		e. DATE OF DEATH <i>MAR. 6 1960</i>		Month		Day Year	
3. NAME OF DECEASED (Type or print) <i>George E. Pointer</i>		First <i>George</i> Middle <i>E</i> Last <i>Pointer</i>		4. DATE OF DEATH <i>MAR. 6 1960</i>		Month	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JUN 11 1887</i>	
9. AGE (in years last birthday) <i>80 yrs</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		11. KIND OF BUSINESS OR INDUSTRY <i>own Farm</i>		12. BIRTHPLACE (State or foreign country) <i>BERLIN MD</i>	
13. CITIZEN OF WHAT COUNTRY? <i>USA</i>		14. FATHER'S NAME <i>GEORGE E. POINTER</i>		15. MOTHER'S MAIDEN NAME <i>MARGARET LILLEY</i>		16. SOCIAL SECURITY NO <i>213-12-3277</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		18. INFORMANT <i>Mrs. G. E. Pointer</i>		19. ADDRESS <i>NOVAKA, MD</i>		20. INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>593</i> DUE TO <i>Acute Cardiac Dilation</i>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Ch. Brights</i>		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
24. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		25. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 28. (City or town) (County) (State) <i>Berlin</i>	
29. I certify that I attended the deceased from <i>Feb 24 - 1960</i> to <i>March 6, 1960</i> that I last saw the deceased alive on <i>March 5, 1960</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Chas. R. Law</i> ADDRESS (Street, city or town, state) <i>Berlin, Md</i> DATE SIGNED <i>March 8-1960</i>		30. PHYSICIAN'S NAME (Type) <i>Chas. R. Law</i>					
31. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		32. DATE THEREOF <i>3/7/60</i>		33. NAME OF CEMETERY OR CREMATORIAL <i>EVERGREEN</i>		34. LOCATION (City, town, or county) (State) <i>BELMONT</i> MD	
35. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Trahan</i>		36. ADDRESS <i>17th & 4th Newark, Dela. Md</i>		37. REC'D. BY REGISTRAR DATE <i>MAR 10 '60</i>		38. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4054

CERTIFICATE OF DEATH

03932

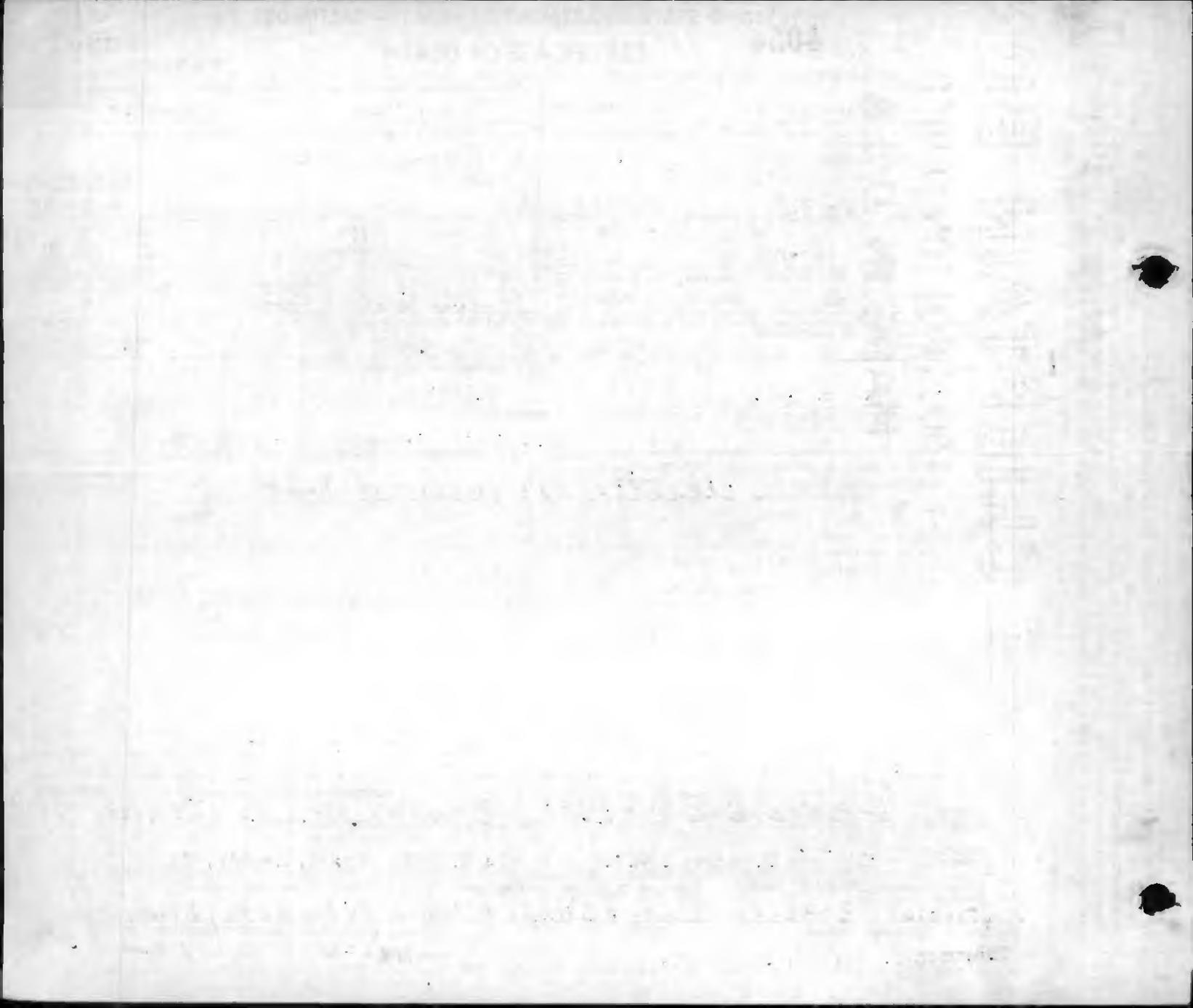
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newark		b. COUNTY Worcester	
c. LENGTH OF STAY IN 1b life time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Newark	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1		d. STREET ADDRESS / Route #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George	First	Middle	Last
4. DATE OF DEATH 3 24 19 60	Month	Day	Year
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-14 1865
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Selby		14. MOTHER'S MAIDEN NAME Talbothy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margie Johnson, Rt #1, Newark, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Acute Myocarditis</i> 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-24-60</i> to <i>3-24-60</i> , 1960, that I last saw the deceased alive on <i>3-24-60</i> , 1960, and that death occurred at <i>9:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clifford E. Schott, M.D.</i>		ADDRESS (Street, city or town, state) <i>314 N. Main Street, Berlin, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-30-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR CHAPEL CEM.</i>		22d. LOCATION (City, town, or county) <i>NEWARK, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		24a. REC'D BY REGISTRAR DATE <i>APR 4 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03993

Reg. Dist. No.

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.
 If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, removal, or removal.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN TB 16	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
3. NAME OF DECEASED (Type or print) CLINTON BOSTON TAYLOR		First Clinton	Middle Boston
4. DATE OF DEATH MAR. 19 1960		Month MAR.	Day 19
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1919
9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT	10b. KIND OF BUSINESS OR INDUSTRY OWN STORE	11. BIRTHPLACE (State or foreign country) NEWARK MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN TAYLOR	14. MOTHER'S MAIDEN NAME MARY BOSTON	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 220-01-8690	17. INFORMANT Mrs. C.B. TAYLOR, BERLIN MD.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 976X		DUE TO Perforating G.S.W. left side of chest	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. through heart,		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Melancholy			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted with 25 cal automatic pistol		
20c. TIME OF INJURY Hour 11 p. m. Mar 19 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Berlin
		20g. (County) Worcestor Co	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Herman A Robbins</i>	DATE SIGNED March 21, 1960		
EXAMINER'S NAME (Type) Herman A Robbins M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/22/60	22c. NAME OF CEMETERY OR CREMATORIAL EVANGELIC	22d. LOCATION (City, town, or county) BERLIN
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Burbage Berlin Md.		24a. REC'D BY REGISTRAR MAR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
ADDRESS		(State) MD	

